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County Borough of Reading



ANNUAL REPORT

OF THE

School Medical Officer

FOR THE YEAR

1958

By

E. HUGHES, M.D., D.P.H.

COUNTY BOROUGH OF READING

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READING EDUCATION COMMITTEE

(as at 31st December, 1958)

HIS WORSHIP THE MAYOR (Councillor Edward Albert Busby)

Aldermen :

JEREMIAH JOHN DWYER
GEORGE WILLIAM HOLLEY

THOMAS STEPHEN WILLIAM SMART

Councillors :

WILLIAM WYKEHAM EDWARD BADNALL
CHARLES EDWARD BUCK
WILLIAM DAVID GOWING
HERBERT WILLIAM LEE
EDITH ELLA LOVETT
ETHEL LOUISA MORAN
INEZ GRACE RANDALL

GEOFFREY VINCENT RICKARDS
DAVID LEONARD STODDART
ALEXANDRA GEORGIA ANDERSON
STURROCK (*Chairman*)
FRANCIS TAYLOR (*Vice-Chairman*)
EDWARD THOMAS WALTHAM
HERBERT WILLIAMS

Co-opted Members :

The Very Rev. Canon J. P. MURPHY
The Rev. D. T. DAVIES
The Rev. R. S. PARKES
The Vice-Chancellor, University of Reading
(Sir JOHN WOLFENDEN, C.B.E.)
Professor C. H. DOBINSON

E. F. ALLWOOD, B.Sc.
W. C. COSTIN, O.B.E.
F. PHILLIPS
A. J. ROBINSON
Mrs. H. D. KAY
Miss D. M. MILES

STAFF AT 31st DECEMBER, 1958

Principal School Medical Officer:

E. HUGHES, M.D., D.P.H.

Deputy Principal School Medical Officer:

G. M. O'DONNELL, B.A., M.B., D.P.H.

School Medical Officers:

VIOLET FRASER, M.B., B.S., M.R.C.S., L.R.C.P.
 ETHEL AMY FISHER, M.Sc., M.B. B.Ch., D.R.C.O.G.
 B. A. SMITH, M.B., B.S., D.P.H.
 H. I. LOCKETT, M.B., B.S., D.Obst., D.R.C.O.G., D.P.H.
 A. MARTIN, M.B., Ch.B. (Commenced 1st July, 1958)
 (on D.P.H. course from October, 1958)

Principal Dental Officer:

J. CAMPBELL, L.D.S., R.C.S. (Ed.)

Dental Officer:

C. A. PANK, L.D.S., R.C.S. (Eng.)

Speech Therapist::

ELIZABETH M. FAIRS, L.C.S.T.
 RITA A. LORD L.C.S.T. (Commenced 1st September, 1958)

Superintendent Health Visitor and School Nurse:

Miss M. WEBBER, S.R.N., S.C.M., H.V.

School Nurses:

Mrs. H. KING	*Miss M. GRANT
Miss M. PLATT	*Miss. S. HANSFORD
Mrs. J. LEWIS (Part-time)	*Mrs. L. KINGSLEY (Part-time)
Mrs. T. PORTER (Part-time)	*Miss H. MORTIMER
Mrs. J. MIDDLETON (Part-time)	*Miss J. SMITH
*Mrs. A. A. ALLISON	*Miss R. UPTON
*Miss F. CLARK	*Miss M. WILLIAMSON
*Miss F. GATES	*Miss E. WOODWARD (commenced 1st July)

*Combined Health Visiting and School Nursing Duties

Oral Hygienist:

Mrs. V. TAYLOR

Clinic Assistants:

Mrs. D. BOXALL Miss B. J. McMANUS Mrs. R. NEALE

Senior Clerk:

Miss. W. M. DIX

READING SCHOOL HEALTH SERVICE

To the Chairman and Members of the Education Committee

Ladies and Gentlemen,

I have the honour to present my report on the School Health Service for the year ended 31st December, 1958. Detailed comments on the many aspects of our work are included in the body of the report and, therefore, I have not referred to them in this introduction

Once again I would like to express my thanks to the Chief Education Officer, his office staff, and teachers in the Reading Schools, for all the help they have given throughout the year. I must also thank the Chairman and Members of the Welfare Sub-Committee of the Education Committee for the interest and support which they have given to this department. My thanks are also due to my own staff for their loyalty and hard work, more especially to Dr. G. M. O'Donnell for his great interest in the work of the School Health Service and his supervision of the compilation of this report.

I am,

Your obedient Servant,

E. HUGHES,

Principal School Medical Officer

ESTIMATE OF THE NUMBERS OF CHILDREN BETWEEN THE AGES OF 5 AND 15 YEARS
IN EACH OF THE NEXT FIVE YEARS

	Between 14 & 15	13 & 14	12 & 13	11 & 12	10 & 11	9 & 10	8 & 9	7 & 8	6 & 7	5 & 6	Total	Increase	Decrease	Cumu- lative incr. or decr.
31st Aug., 1958	1,721	1,710	1,768	2,146	1,925	1,773	1,708	1,680	1,644	1,617	17,692	—	—	—
31st Aug., 1959	1,710	1,768	2,146	1,925	1,773	1,708	1,680	1,644	1,617	1,566	17,537	—	155	—155
31st Aug., 1960	1,768	2,146	1,925	1,773	1,708	1,680	1,644	1,617	1,566	1,595	17,422	—	115	—270
31st Aug., 1961	2,146	1,925	1,773	1,708	1,680	1,644	1,617	1,566	1,595	1,581	17,235	—	187	—457
31st Aug., 1962	1,925	1,773	1,708	1,680	1,644	1,617	1,566	1,595	1,581	1,713	16,802	—	433	—890
31st Aug., 1963	1,773	1,708	1,680	1,644	1,617	1,566	1,595	1,581	1,713	1,695	16,572	—	230	—1120

SCHOOL CLINICS

QUEEN'S ROAD CLINIC—

Minor Ailments	...	...	...	Monday and Friday, 9 a.m. 10 a.m.
Ultra-Violet Light Therapy	...	...	...	Tuesday, 2.30 p.m., Friday, 10.30 a.m.
Ringworm Clinic	...	...	...	Wednesday, 2 p.m.

WHITLEY CLINIC—

Minor Ailments	...	...	...	Monday and Friday, 9 a.m.-10 a.m.
Ultra-Violet Light Therapy	Monday and Wednesday, 11.30 a.m.

ASHMEAD SCHOOL CLINIC—

Minor Ailments	Friday, 2 p.m.-3 p.m.
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EMMER GREEN SCHOOL CLINIC—

Minor Ailments	Friday, 9 a.m.-10 a.m.
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GEOFFREY FIELD SCHOOL CLINIC—

Minor Ailments	Wednesday, 9 a.m.-10 a.m.
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HILL SCHOOL CLINIC—

Minor Ailments	Wednesday, 9 a.m.-10 a.m.
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GROVELANDS SCHOOL CLINIC—

Minor Ailments (for Battle School)	Monday, 9 a.m.-10 a.m.
„	„	„	...	Friday, 9 a.m.-10 a.m.

HUGH FARINGDON SCHOOL CLINIC—

Minor Ailments	Wednesday, 9 a.m.-10 a.m.
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ST. MICHAEL'S SCHOOL CLINIC—

Minor Ailments	Wednesday, 9 a.m.-10 a.m.
----------------	-----	-----	-----	---------------------------

SOUTHCOTE PRIMARY SCHOOL CLINIC—

Minor Ailments	Tuesday, 9 a.m.-10 a.m.
----------------	-----	-----	-----	-------------------------

STONEHAM SCHOOL CLINIC—

Minor Ailments	Tuesday, 9 a.m.-10 a.m.
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WESTWOOD SCHOOL CLINIC—

Minor Ailments	Monday, 9 a.m.-10 a.m.
----------------	-----	-----	-----	------------------------

DENTAL CLINICS—

Queen's Road Clinic
Whitley Clinic

SPEECH THERAPY CLINICS—

Ashmead School	...	...	1 Session	The Hill School	...	1 Session
Avenue School	...	...	4 „	Queen's Road Clinic	8	„
Emmer Green School	...	...	1 „	St. Michael's School	1	„
E.P. Collier School	...	...	1 „	Southcote School	2	„
Geoffrey Field School	...	...	3 „	Whitley Clinic	2	„
Grovelands School	...	...	2 „			

NUTRITION

The following table shows the number of children with nutritional defect, diagnosed at periodic medical inspections during the past five years.

1 Year	2 Pupils medically inspected	3		4	
		MALNUTRITION		OBESITY	
		No.	% of Col. 2	No.	% of Col. 2
1954	4,754	35	0.7	67	1.4
1955	5,530	20	0.3	70	1.3
1956	5,124	25	0.4	74	1.4
1957	5,621	13	0.2	73	1.3
1958	4,655	27	0.6	80	1.7

For the past five years there has been a remarkable constancy in the number of school children found at each extreme of the nutritional level. The very low incidence of malnutrition may be contrasted with that of obesity which, apart from its greater frequency, presents a more intractable problem. It is relatively simple to help and sustain the undernourished child but to take weight off those conditioned to years of overfeeding, whether due to personal inclination or familial example, is no easy task. Effective dieting is even more difficult where underlying tensions seek relief in gormandising or in those rarer cases of glandular dysfunction in which food intake may not be unduly excessive. To most minds, fatness is synonymous with joviality and contentment and only those so afflicted realise how crabbed and constrained life can be, encaged in useless avoirdupois and a martyr to breathlessness and flat feet. Perhaps Shakespeare, with customary perspicacity, expressed this viewpoint best when he wrote

“ Fat paunches have lean pates; and dainty bits make rich the ribs, but bankrupt quite the wits.”

SCHOOL MEALS SERVICE

The year 1958 has been an interesting one for the School Meals Service. Three new canteens were opened, and the percentage of children eating dinners at maintained schools increased to 44.06% of those present, which is the highest percentage achieved up to the present time in this Borough.

The extension of the Avenue School for the physically handicapped has its own new kitchen to provide breakfasts, on medical advice, and dinners for approximately 75 children. Miss Collins, who has worked for 39 years in this school was promoted cook-in-charge of the new kitchen, when it opened on 6th January, 1958. When the children came into their new dining room they said “ It’s Miss Collins ”—their delight and pleasure was obvious. Miss Collins prepares the special diets as well as the usual school dinners and the children, who sit at tables of eight, are served by Miss Collins and her helpers from a trolley; in this way it is simple to give the children their special diets, whilst still allowing them to sit with their friends.

A canteen was provided at Hugh Faringdon Roman Catholic Secondary School which opened on 22nd April, 1958. Carried meals were provided until 2nd May, when the first meal was cooked on the premises. The staff had a difficult task as the work in the kitchen was still not finished. “ Family Service ” was provided and, owing to training and supervision by the teachers, has become a successful scheme.

Reading School has had a kitchen built on to the existing scullery and dining room. The kitchen had to be fitted into the existing shell of a covered play area, and has formed a most attractive and satisfactory kitchen. Meals were cooked on 16th September, 1958, under considerable difficulties, owing to the work on the kitchen not being finished in time. A "Trolley Service" has been provided at this school; the main dishes are served from trolleys and the vegetable dishes, gravy and sauces are placed on the tables for the boys to help themselves. This service appears to be most satisfactory.

The Ministry of Education gave their approval to a training scheme for Cadet Cooks for girls who wish to train as Cooks or Cook Supervisors in the School Meals Service. In September two Cadets were accepted for training and they are making good progress both in their practical work in the kitchens and in their classes at the Technical College. It is anticipated that they will pass the Catering Trades Basic Training Course No. 150 examination in June, 1960. They will then be qualified to take a post as assistant cook or cook. They will have the opportunity of attending the College for a further year in order to take another qualification—the Cookery for Hotels and Catering Establishments Course No. 151. These two qualifications are recognised for additional pay when held by a Cook Supervisor or Supervisor. At the present time, 14 adult members of the School Meals Service have taken, or are taking, these courses and the standard of cooking and finish in our kitchens has improved.

When trying to see what progress has been made, it can be seen most readily by comparing the present position with that of a few years ago. The standard of cooking has definitely improved and correct methods are now generally used. When the dining tables are laid they look much more attractive and the improvement in the children's manners is most noticeable. It is fascinating to see the results where children are definitely taught to use their cutlery correctly, and the remarkable success that has been achieved is entirely due to the persevering work of the teachers.

HANDICAPPED CHILDREN

Accommodation—The new extension to the Avenue School was opened in January. This provides ample facilities for the physically handicapped and delicate departments and by releasing accommodation in the old school, permits the intake of a further forty educationally subnormal children. It includes a classroom for younger children suffering from cerebral palsy, a physiotherapy room, and a splendidly equipped housecraft centre. Sited on a gentle rise, overlooking well-wooded gardens, the new school realises those qualities of peace and æsthetic harmony so desirable in the education of handicapped children and represents a notable landmark in the service offered by this authority.

(a) *Blind*—One boy attends Condover Hall, Shrewsbury, and a girl is resident at Sunshine House Nursery School, Leamington Spa. One other girl was reclassified as partially sighted and is making good progress at Barclay School.

(b) *Partially Sighted*—Five girls are resident at Barclay School, Sunninghill, and three boys at Blatchington Court, Seaford.

(c) *Deaf*—At present there are three boys on the deaf register, two of whom attend residential special schools, to wit: Nutfield Priory and St. Thomas' School, Basingstoke. The third boy has a double handicap of deafness and bronchiectasis, the latter being of such a serious and debilitating nature that it takes precedence over the deafness from both the medical and educational viewpoints. Accordingly he attends the physically handicapped department at the Avenue School where he receives help on a peripatetic basis for his deafness.

(d) *Partially Deaf*—Four children, three girls and one boy, all of senior school age, attend the school for the partially deaf at Brighton. Eight children attend the

Palmer Unit as full-time pupils and five more attend the Palmer School and receive part-time special help. Six children at present attend the New Town Unit as full-time pupils. J.D., one of the cases described in last year's report, remains as a part-time pupil.

The following summary shows how distribution of cases has changed during the past two years, mainly through the provision of units. Many of the children in the units have hearing losses averaging from 70-100 db. These are now regarded as partially deaf. This accounts for the preponderance of partially deaf as opposed to deaf who are receiving special educational treatment at present.

	1956	1958
Provision at residential schools for the deaf	10	2
„ „ residential schools for the partially deaf	5	4
„ in Units for partially deaf children	10	14
Returned from units to normal classes	2	12*
Awaiting unit treatment	7	2
Total ...	34	34

* Five of these children receive part-time special help.

Four of the 34 children shown in the 1958 column were from families which moved to the district especially so that the child could be educated in the units. A fifth child moved to Reading for a similar purpose but left before taking a place in the unit. It is now quite normal for the authority to receive enquiries for vacancies in the units from far and wide.

Admissions to the Units

Of the first three children admitted to New Town Unit, one (J.D.) has been returned to an ordinary class in the main school. He receives occasional special help (see below). The other two children (N.C. and J.S.) were transferred to the Palmer Unit in September 1958. Case notes on J.D. and the six children admitted to New Town Nursery/Infant Unit are as follows:-

J.D.—Male. Aged 6 years (see last year's report).

This boy has made very good progress in all fields. From September to December he spent most of his time in the normal class and will continue there full-time. Reading age 7 years 6 months. Chronological age 6 years 10 months. Speech is virtually normal, language development is not quite equal to that of a comparably bright child. Occasionally lacking in confidence.

D.B.—Female. Aged 5 years 3 months on admission in January, 1958.

Previous history—Mother Rh-ve, child was severely jaundiced just after birth. Partial deafness was diagnosed at 3 years 8 months. Slight spasticity was also present. Hearing aid was issued and the child attended normal nursery. She had some help from the speech therapist. Educational Capabilities—language development; when admitted this child's spoken vocabulary was small and indistinct, and associated with poor control of tongue muscles. Her understanding of language was rather better, though very limited. Concentration was very poor. By the end of the year, she had made a beginning in reading and number work, and her spoken language was largely intelligible. Concentration showed signs of improving.

S.P.—Female. Aged 4 years 8 months on admission in January 1958.

Previous history—deafness could have been caused by either hereditary factors or by anoxia at birth (8 month baby). Did not start to speak. Deafness suspected about 18 months but not diagnosed until 3 years. Mother had training at Ealing Hostel and when the child entered the nursery, she could speak in single clear words and some two or three-word phrases. Had frequent temper tantrums. She took considerable time to settle down. She entered the infant school in April. By the end of the year she had made a very good beginning in reading and counting, and language development could be said to be at 3-4 year level. She chatters freely and socially she has made tremendous strides. She is developing in confidence though still requiring constant reassurance in new situations.

W.P.—Male. Aged 6 years 10 months on admission in June 1958.

Previous history—catarrhal ear trouble from 2½ years. Previously attended ordinary school. Educational Capabilities—I.Q. average; language development normal; speech normal except for substituting “f” for “th”; reading and arithmetic were almost two years retarded; emotionally unstable, home conditions not very good. Had become a behaviour problem at his school, was aggressive, lazy and uninterested. A hearing aid was issued on entry, the main aim was adjustment to handicap, including use of hearing aid and the fostering of a new attitude to learning. By the end of the year he had become much more adjusted, was more pleasing and showed some interest in work. As he had no communication problems he was then returned to normal school where he could have the help of a remedial teacher.

S.G.—Female. Aged 6 years on admission in September 1958.

Previous history—broken home followed by placement in C. of E. home. Did not develop speech. Partial deafness, a severe high tone loss, was diagnosed in February 1958. Emotionally very disturbed. A hearing aid was issued in March 1958 and help was given by a speech therapist. On entry to the Unit she had already developed simple language structures and speech was fairly good apart from sibilants. The main problem has been to foster a sense of security. Very lacking in concentration. She is a year retarded in reading and number work and about two years in language development.

A.E.—Male. Aged 5 years 6 months on admission in September 1958.

Previous history—diagnosed as severely deaf at 3½ years. Hearing aid issued at 5 years. Attending lip-reading class part-time. Had developed no speech or language. Communication was entirely by gesture. Unable to dress himself. By the end of the year he was babbling and had about thirty clear words, understood a few phrases.

In the Palmer Unit three of last year's class remain. (T.H., E.G., and C.B.) The boy, T.H., is almost ready for return to normal class. Both girls have marked hearing loss and would formerly have been regarded as Grade III children. Six new admissions were made during 1958, as follows:-

From Newtown

N.C.—Male. Aged 8 years. I.Q. (WISC)—106. Admitted in September 1958.

This boy has made good progress in the Nursery/Infant class. He had a sound foundation of reading and number and his language was spontaneous and completely intelligible. He had acquired a good attitude towards school and work. He shows promise of speedy rehabilitation.

J.S.—Male. Aged 9 years. I.Q. (WISC)—75. Admitted in September 1958.

This boy had made good progress in the New Town Class in speech and language but, being dull, had learned little more than the fundamentals of reading and number. Nevertheless, with fairly good communication skills his barrier to learning now stems mainly from spasticity and dullness. He is settling down to work and has shown some progress.

J.S.2—Male. Aged 11 years. I.Q. (WISC)—112. Admitted from January to September 1958.

This boy, formerly at an ordinary junior school, was retarded by two years on admission. This backwardness was cleared up within eight months and he is now holding his place comfortably in an ordinary class. He is a definite behaviour problem.

K.R.—Male. Aged 9 years 8 months. I.Q. (WISC)—85. Admitted in September 1958

This boy, who attended an infant school in the Borough, was admitted when it was apparent that education in an ordinary class was causing emotional disturbance. He also has an eye defect (asthenopia). He has made sound but slow progress throughout the year.

P.S.—Male. Aged 9 years. I.Q. (WISC)—95. Admitted in September 1958.

This boy had spent five years at a residential school for the deaf before admission. Speech on admission was not intelligible to the staff of the school, nor was there any noticeable improvement during the period September to December. This boy had a reading age of 6.0 on admission; he obtained no score on Schonell's arithmetic tests, but could add and subtract simple numbers. He had no concept of division or multiplication. He is an emotionally disturbed child and makes no social contacts either at home or at school.

R.H.—Male. Aged 8 years. I.Q. (WISC)—115. Admitted in September 1958

This boy also had spent five years at a residential school for the deaf before admission. He had a reading age of 6.3 on admission, but no sense of number whatsoever. After three months in the unit he still cannot add more than single digits. Severely emotionally disturbed and aggressive, this child now has a few intelligible words. On admission even his mother could understand only his simplest needs, then by gesture more than speech. Like *P.S.* he has useful hearing but does not yet use it.

1. NEW TOWN

Name	Frequency in c.p.s.				
	250	500	1,000	2,000	4,000
<i>J.D.</i>	30db.	45db.	70db.	70db.	60db.
<i>W.P.</i>	15db.	15db.	15db.	15db.	15db.
<i>D.B.</i>	30db.	55db.	65db.	55db.	80db.
<i>S.P.</i>	75db.	90db.	85db.	85db.	70db.
<i>S.G.</i>	25db.	40db.	60db.	65db.	70db.
<i>A.E.</i>	75db.	85db.	85db.	90db.	90db.



AUDIOMETRIC TESTING



2. PALMER

Name	Frequency in c.p.s.				
	250	500	1,000	2,000	4,000
C.B.	70db.	90db.	90db.	90db.	100db.
E.G.	55db.	65db.	85db.	85db.	75db.
T.H.	20db.	50db.	60db.	80db.	65db.
R.H.	80db.	90db.	105db.	100db.	100db.
P.S.	75db.	95db.	95db.	85db.	70db.
C.N.	25db.	30db.	30db.	35db.	25db.
J.S.1.	25db.	35db.	65db.	85db.	85db.
J.S.2.	35db.	35db.	30db.	40db.	40db.
N.C.	25db.	30db.	60db.	80db.	80db.
M.O'B	45db.	45db.	60db.	70db.	65db.
A.S.	30db.	50db.	65db.	75db.	90db.
T.A.	0	10db.	50db.	55db.	50db.
K.R.	40db.	35db.	40db.	35db.	40db.

Hearing loss of children awaiting admission :-

Name	Frequency in c.p.s.				
	250	500	1,000	2,000	4,000
K.H.	55db.	60db.	65db.	70db.	65db.
J.G.	75db.	90db.	105db.	100db.	100db.

Sweep audiometry:-

Children with hearing loss who attend normal school, excluding former unit pupils, now number 162, of whom 36 wear hearing aids. This increase in numbers of children known to have defective hearing is largely due to sweep frequency audiometric testing of school entrants. The results of this work are as follows:-

Audiometric Survey:-

1. Total number of children tested 9.9.58 to 9.12.58 ... 1,130

2. Total number who failed sweep test:-

(a) Referred to E.N.T. specialist	...	...	...	32
(b) To be reviewed	...	...	...	15
(c) Discharged	...	...	...	2
(d) Waiting to be seen by S.M.O.	...	...	...	70

That 70 children are at present waiting to be seen by School Medical Officers is due to change of audiometricians. It is now the practice of all children who fail the sweep test to be reviewed by a doctor and audiometrician at a special clinic prior to referral to the E.N.T. specialist. This procedure was instituted to limit the number of children referred to the hospital.

School Audiology Centre—The large number of children failing the sweep test and requiring further review, and the necessity for having some central and suitable place in which to examine selected cases, has been met by the provision of a special audiology centre at the central school clinic. This consists of a partially sound-proofed room equipped with audiometer and tape recorder and is shared by both audiometricians and speech therapists. All records, including a comprehensive register of those children with hearing defect, are kept at this centre.

Pre-school Detection Schemes—In last year's Report, mention was made of schemes whereby Health Visitors and School Welfare Officers reported cases of suspected deafness or retarded speech development in pre-school children. In addition to these measures all nursery children with hearing loss have been tested for deafness. Results of detection among under-5's are as follows:-

Referred by	Children with defective hearing	Children with normal hearing	Total
Health Visitors ...	6	6	12
School Welfare Officers ...	16	3	19
Nursery School ...	14	23	37
Other ...	3	—	3
Total ...	39	32	71

It is of interest that only one child was found to have deafness of the perceptive type. In this case a hearing aid was issued. All others responded favourable to treatment.

Incidence of deafness amongst spastic children—As children affected with this condition are among the groups particularly vulnerable to hearing defect, they were audiometrically examined during the year and the results are given below:-

Away at residential school (not tested)	...	...	...	...	1
No response to tests	...	...	...	...	1
Hearing within normal limits	...	...	...	...	29
Deafness of educational significance	...	...	...	...	4

Of the four children with significant hearing loss, two are attending partially deaf units while the other two require no more than a favourable position in class.

(e) *Educationally Subnormal*—During the year 107 children suspected of being educationally subnormal or in serious educational difficulty were examined by the approved Medical Officers. In each case the examination consisted of an intelligence test, at least one performance test, and a physical examination.

The following list gives the results of the assessments of these children:-

<i>New Cases:-</i>							<i>Boys</i>	<i>Girls</i>
Total number of children examined	...	...	...	...	...	...	55	16
E.S.N. children recommended for special school	...	...	...	...	...	...	15	5
E.S.N. children recommended for remedial teaching at ordinary school	...	...	...	...	...	...	29	8
E.S.N. and maladjusted	...	...	...	...	...	...	3	1
E.S.N. and other significant defects	...	...	...	...	...	...	5	5
Ineducable	...	...	...	...	...	...	5	1
Average Intelligence	...	...	...	...	...	...	7	2
<i>Reviews</i>								
Total number of children examined	...	...	...	...	...	...	29	7
Recommended for special schooling	...	...	...	...	...	...	9	3
For remedial teaching at ordinary school	...	...	...	...	...	...	7	2
E.S.N. and Maladjusted	...	...	...	...	...	...	3	2
For statutory supervision...	...	...	...	...	...	...	3	1
Ineducable	...	...	...	...	...	...	1	0

It is perhaps worthy of comment that in 28 instances the home circumstances were such as to impose a further burden upon immature and struggling minds. In the majority this resulted from lax standards of morals and discipline, but twelve of these children had to cope with parents of subnormal intelligence and six came from broken homes. There can be few more pathetic sights than that of the subnormal child, trying hard to make a success of his schooling, only to have his confidence and abilities consistently undermined by parental indifference and neglect. Unfortunately in this respect he is more vulnerable than the ordinary child and can only oppose this final betrayal by either retreating into a state of impassivity and rejection or else expressing his despair in a variety of behaviour disorders.

Cross Laterality—A survey of these children show that almost a third were cross laterals of eye and hand (27) or were left-handed with accompanying reversal symptoms (7). In each case the educational abilities were well below the standard appropriate to the mental age. Where the dull child is concerned, cross laterality represents yet another brake on the intellect and should always be suspected by a teacher when a child fails to reach an educational level consistent with its ascertained intelligence. By and large, intelligent children soon adjust to this condition and it is only amongst those less fortunately endowed that it exerts its silent but very frustrating effects.

(f) *Epileptic*—The School Health Service has under observation 25 pupils who suffer either from *grand mal* or *petit mal* forms of epilepsy. Two children are resident at Lingfield School, seven attend the Avenue School, one child with a double handicap has home teaching and the remainder, who are mostly cases of *petit mal* or *grand mal* of infrequent occurrence, attend ordinary schools. Severer cases attend the Avenue Special School where careful supervision and adherence to regimen curtail the frequency and severity of the seizures. Special care is taken to see that the child remains alert and interested as intellectual preoccupation is a recognised factor in the prevention of epileptic attacks.

In many ways the old atavistic dread of the epileptic still persists and there is a reluctance to assume any responsibility in such cases, although this may be disguised as a concern for their safety. Since it is important that these children should remain in a normal environment and not be exposed to any form of social apartheid, the attitude of the teaching profession in Reading in their acceptance of the epileptic child is both generous and prescient.

(g) *Maladjusted*—A maladjusted child is a child who shows evidence of emotional instability or psychological disturbance and requires special educational treatment in order to effect his personal, social or educational readjustments.

Unfortunately the term “maladjusted” seems to have become part of the jargon of social medicine and although it may be a convenient administrative classification it tends to be used, quite wrongly, to describe a clinical entity. The justification for applying this classification varies considerably, and no doubt depends on the views of the individual doctor dealing with the child. This is well shown in one item on page 172 of the Underwood Report, where it is stated that in 1949 a survey was made by a psychiatrist of all the 8-year old boys in a primary school in a borough of outer London and 42% were judged to be maladjusted. Another survey of 18-year old males reported on the same page states that a total of 42% were maladjusted. It is evidence of this sort which makes many people view with considerable reserve the whole subject of child psychiatry.

By the end of the year we had not received the views of the Ministry of Education on this Report but my own views, for what they are worth, are that this Report supports a continuation of a procedure which is outmoded and does not pay sufficient attention to recent developments in psychiatric practice. I would commend the views expressed in a survey of child guidance services carried out in the Oxford Hospital Region and, at the same time, express a hope that it may be possible to integrate more closely the child psychiatric service with other mental health services under the new Mental Health Act.

New cases attending the Child Guidance Clinic in 1958 have been analysed according to the causes of maladjustment and the presenting symptoms, the results being shown in the following tables. Where these were multiple, only the dominant symptom or cause was recorded.

Causes of Maladjustment

	Boys	Girls
Parental Disharmony	10	0
Rejection by mother	0	1
Personality defect of parents	9	2
Lax parental standards	4	2
Absence of parents	2	2
Personality defect of child	8	6
Removal from home	2	0
Sibling jealousy ...	2	1

Presenting Symptoms

	Boys	Girls
Truancy	5	1
Anxiety reactions ...	11	6
Aggression	11	6
Psychosis	0	2
Pilfering	8	0
Soiling	2	0
Stammer	0	1

The standard of intelligence of these maladjusted children is shown in table:-

I.Q.'s	50-70	70-90	90-110	110-130
Boys	2	4	25	5
Girls	1	4	8	2

The report of Dr. M. E. Ward, Psychiatrist, Reading Child Guidance Clinic, reads:-

There have been no changes or new developments in the Reading Child Guidance Clinic during the year. The clinic is keeping up to date with new cases referred, urgent cases can be seen within a week or two and most cases are seen within 5-6 weeks of referral. There is not a long waiting list for treatment, only a small number of cases are selected for regular weekly treatment, the large majority of cases are treated by advice to parents or schools with follow-up visits to check progress. More intensive treatment of mother and child has been handicapped by the lack of a Psychiatric Social Worker most of the year. Mrs. Crossman kindly returned to give us some help, 1-2 sessions weekly from May to September, and we are fortunate in obtaining the temporary services of an experienced American Psychiatric Social Worker, Mrs. Rogosa, 6 sessions weekly from mid-October.

The clinic is very sorry to lose the services of our Educational Psychologist, Mrs. Scott Blair, who resigned on 31st December, 1958. Mrs. Scott Blair has served the Joint Berkshire and Reading Child Guidance since 1941, and the Reading Child Guidance since April, 1957. Mr. Newham has been appointed to fill the vacancy and will take up the post on 1st April, 1959.

All Children seen at Reading Borough Clinic from 1st January, 1958, to 31st December, 1958:-

No. of Cases brought forward from 31.12.57	...	...	...	...	...	140
No. of New Cases referred...	...	...	...	...	...	79
No. of Cases re-opened during the period	...	...	...	...	...	7
Total No. of Cases seen for Consultation and Treatment	...	...	...	...	...	173
Total No. of Cases treated	...	...	...	...	...	62

No. of Cases closed	...	...	...	...	...	71
After consultation and Advice only	...	...	...	...	...	11

No. of Cases treated and closed:-

Adjusted	...	...	...	...	...	4
Improved	...	...	...	...	...	15
No change	...	...	...	...	...	5
Closed after advice and supervision	...	...	...	...	...	21
Prematurely Closed	...	...	...	...	...	6
No. of Cases closed not seen	...	...	...	...	...	8
No. of Cases closed after Social Work only	...	...	...	...	...	1

No. of Interviews:-

For Psychiatric Examination	...	...	...	...	...	75
For Intelligence Test...	...	...	...	...	...	75
For Treatment, including remedial coaching	589

No. of P.S.W. and S.W. Interviews	103
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No. of children admitted to Hostels for maladjusted Children...	7
No. of children discharged from Hostels for Maladjusted Children	4
No. of children in Hostels on 31.12.58	...	...	10

Sources of Referral, Child Guidance Clinic Cases, from 1st January, 1958, to 31st December, 1958.

School Medical Officers	49
General Practitioners	15
Probation Officers	6
Children's Officers	2
Hospitals and other Psychiatric Clinics	6
Teachers	1
							Total	79

(h) *Physically Handicapped*—Only four children need residential schooling the remainder of the physically handicapped attend ordinary schools, the appropriate department of the Avenue School, or require home teaching.

Those receiving education at residential or day special schools are classified, according to defect, as follows:-

							Boys	Girls
Congenital	{	Haemophilia	...	...	...	...	1	0
		Fragilitas ossium	...	...	...	...	1	1
		Spina bifida	...	...	...	...	1	1
		Congenital deformities	...	...	...	...	0	5
		Heart conditions	...	...	...	...	3	1
		Cerebral palsy	...	...	...	...	3	4
		Muscular dystrophy	...	...	...	...	2	0
Acquired	{	Amputation	...	...	...	...	2	0
		Traumatic paresis	...	...	...	...	1	0
		Post-T.B. meningitis	...	...	...	...	1	0
		Obesity	...	...	...	...	0	1

Where possible the physically handicapped child is retained in the ordinary school so that his feelings of difference and diffidence may be prevented or effaced. Admission of suitable cases to a nursery school is helpful in adjusting these children to the hurly-burly of school life and enabling them to come to terms with their handicap at an early age. In Reading we are fortunate that the occasional severely handicapped child deemed suitable for an ordinary school is accepted willingly by both staff and pupils. Indeed, where the latter are concerned, their zeal and pleasure in assisting the handicapped child may, at first, even prove an embarrassment as he is as anxious and determined to show his independence of them as they are to help him. However, within a short while these difficulties are resolved and an honourable compromise established. It is true to say that the continuance of many handicapped children at ordinary schools depends to a great extent on the discreet assistance and willingness to assume extra responsibility that typifies the school community.

Special Class for Cerebral Palsy.—This class, sited in the new extension to the Avenue School, opened in January with a complement of six severely handicapped children. The teacher in charge, who is assisted by a trained nursery nurse, has no other commitments and is thus enabled to give individual attention to each child. The

equipment includes Aris Bainbridge chairs, a large playpen for younger children and specially designed toilets to which there is direct access from the classroom. Immediately adjacent is a physiotherapy room, thus permitting the regular attendance and concentrated treatment so desirable in these cases. Transport is provided between home and school, and school dinners are taken in the company of the other children of the physically handicapped and delicate departments. It is important that these children, so restricted in their enjoyment of the wide compass of normal life, should have no feelings of isolation or exclusion and these can be prevented by mixing with more fortunate children at meals and other communal activities. It is usually difficult to determine the educability of a spastic child because physical disabilities often mask latent talent and in addition to motor handicap, defects of vision and hearing or a mental delay in responding to conversation, further undermine their ability and confidence. Two of the children attending the unit, both terribly incapacitated, would undoubtedly appear ineducable to the cursory examiner although those in constant touch with them are convinced that behind the facade of gross handicap lies a frustrated intelligence powerless to express itself. For these reasons the purpose of the class is largely one of trial and observation in which individual needs can be assessed and a genuine evaluation of intelligence attempted.

At present children between the ages of four and eleven years are admitted to the class. However, in view of the increasing importance attached to early treatment and training the possibility of catering for even younger children must be seriously considered.

Classification of Cerebral Palsy Cases

(1) According to Educational Potentialities						(2) According to Age		
							Boys	Girls
(a)	Pre-school	...	...	...	...	Under 5 yrs.	5	4
(b)	Ordinary school	...	...	...	...	5-10 yrs.	9	8
(c)	Avenue Special school	...	...	...	...	10-16 yrs.	10	4
(d)	Cerebral Palsy class at Avenue School	...	...	...	...
(e)	Residential schools	...	...	...	...
(f)	Formally ascertained as ineducable	...	...	...	...
(g)	Partially deaf unit	...	...	...	...

(i) *Delicate Department*—Dr. H. I. Lockett reports:-

Of the 23 children on the roll of this department at the end of 1958, 7 had bad chests (asthma, bronchiectasis, fibrosed lung), 2 had cleft palates, 1 was incontinent as a sequel to tuberculous meningitis, 1 was severely diabetic, and the remainder had no specific defect but were delicate or debilitated at the time of admission. Multiple physical handicaps were not uncommon and several of the children had some deafness or bad eyesight for example, in addition to other problems. Boys were clearly in the majority, only 4 of the pupils being girls. Regarding age, only 3 pupils were under 11 years old at the end of the year.

I think it would be fair to say that a casual visitor to the school would not see many obviously delicate children. Those who are weak and debilitated on admission from an ordinary school usually rapidly improve in the less exacting climate of the Delicate Department, but they are often retained in the department because their

problem is rarely one of delicate physical health alone. In almost every case admitted to the school there is an element of educational retardation and emotional instability is common. It is in overcoming these, that the individual teaching methods and the less intense non-competitive atmosphere of the school is invaluable. Above all, these so unfortunate children need sympathetic handling and constant friendly encouragement.

The educational retardation may result from repeated absences from school due to ill-health. A child of high innate intelligence will frequently be able to make up lost ground by its own efforts. The less favourably endowed need special help and it is in helping children of this type that the Delicate Department finds its chief justification. An effort has been made to assess the intelligence quotients on the Terman-Merrill Scale of all the children in the department. When those children suffering from chest weaknesses are excluded (our figures for these are incomplete as yet) it is noted that none has an I.Q. above 100. The lowest is 59 and the majority fall in the 80's. Even so this range shows that the children are likely to have widely differing levels of educational achievements and individual educational needs.

It must not be thought, however, that the traditional features of the open-air school, such as supplementary meals, extra nourishment, exercises and periods of rest, no longer matter. They still have an important part to play in some cases and postural drainage and breathing exercises, for example, are regularly supervised for certain of the chest cases.

Although these physical measures still have a place, I would feel that the essential feature of the Delicate Department is the particular type of environment it provides, with physical, intellectual and emotional aspects each adapted to meet the needs of these highly individual children with problems and disabilities which make them unable to fit in adequately in the ordinary school environment.

(j) *Speech Defects*—Miss Fairs reports:-

251 children attended the speech clinic during 1958—170 boys and 81 girls

83 discharged cured or greatly improved

11 discharged for non-attendance

4 left district before treatment was completed

2 referred to special schools—Moor House and John Horniman's School

1 referred to deaf unit

1 refused treatment

102 children were taken off the register

149 continued into 1959

142 cases of dyslalia

3 cases of dyslalia due to deafness

7 cases of retarded speech development due to low intelligence

13 cases of retarded speech development

41 cases of stammering

16 cases of stammering and dyslalia

10 cases of cerebral palsy

7 cases of cleft palate

2 cases of dysarthria

10 cases of disordered vocal resonance

Clinics were held at Queen's Road, Whitley, Caversham, and Southcote centres. School clinics were held at the Avenue, Emmer Green, The Hill, E.P. Collier, Southcote, St. Michael's, Ashmead, and Battle Schools. Two clinics—Caversham clinic and Battle school clinic closed during the year and the children receiving treatment were transferred to other clinics.

We have held a greater number of sessions per week this year as two speech therapists have been working full-time and a third speech therapist has been working part-time; twenty-four sessions per week has enabled us to avoid acquiring long waiting lists.

A certain amount of time has been set aside for school and home visits.

Stammering—As this condition is comparatively difficult of solution and requires a good deal of therapeutic care, it is opportune to discuss it in relation to the attitude and treatments which we employ in Reading.

Stammering may be defined as a disturbance in the smooth flow of speech due to the repetition or holding of a sound. It is distinguished in two phases: (i) Primary (ii) Secondary.

A primary stammer occurs in the initial stages of the disorder before the child is actually aware of the effect and before he has become anxious about it. It is characterised by the repetition of one sound or a series of sounds, rather than the holding of a sound. Of course, some children go through a normal stage of syllable or, more often, word repetition when about three years old; although it resembles the primary stage of stammering as described above, the child should pass through this stage as his capacity for expressing ideas through speech is matured. It is only the child who has a tendency to stammer who may develop further symptoms of this disturbance. Parents, and indeed anyone, who has contact with the child can help to prevent the development of stammer from these early beginnings, by a sensible attitude and calm handling of the child.

In the secondary stage, the symptoms are more severe and by the time the stammerer reaches school age he is more aware of his difficulties. It is these school children whom the speech therapist has most occasion to treat and who comprise 30% of the attendances at our clinics. About half these children are also found to have dyslalia (an articulatory defect) and in these cases the speech therapist has to decide which of the two defects ought to be treated first, and in making her decision she will take into consideration which defect the child himself is most concerned about.

People often ask "what is the cause of stammering?" This has puzzled scholars for centuries. Hippocrates held that stammering was due to "dryness of tongue," Aristotle accused a "too thick and too hard tongue" and although many advances have been made in both theory and treatment since the dawn of medicine, it is still a subject of much controversy. Is it hereditary? There are no definite hereditary factors to be found in stammering although there is familial tendency. What relative importance does the factor of imitation play in stammering? In early years a child may playfully imitate a stammering parent or play mate, but this will not have a lasting effect unless the child has an initial tendency to stammer. The forced reversal of handedness from left to right used to be raised as one of the factors causing stammering, but this is no longer relevant as in the majority of cases the natural dominance of either left or right hand is allowed to develop in childhood. Most authorities believe stammering to be psychological in origin and it is one of the ways in which people react to the stress of everyday life. It is also widely acknowledged that certain factors can contribute to the appearance of a stammer in an individual and for maintaining and developing it. A sudden shock, either emotional or physical, can lead to the appearance of a stammer in any individual who has a tendency towards stammering and this can occur at any age; for example, as was shown by the number of troops who began to stammer for the first time under the stress of warfare. A

second example is shown by the young child who developed a stammer when told at school that his house was being burnt down and his mother trapped inside—he rushed out of school and raced home to find that this was an exaggeration, but the shock to the child was so great that a stammer was the result.

During the past year a questionnaire has been compiled for all the stammerers that attend our clinics, and all agree that their stammer becomes more severe when excited or tired ; that their stammer becomes worse at school under stress, such as answering questions or the register. These children will obviously dislike such situations which they fear may prove unpleasant for them as they require verbal replies and to feel free and happy about speaking, they must become confident that they are capable of speaking fluently, and this is one of the points the speech therapist keeps in mind during treatment.

Speaking is the main form of communication and it is very important that every young stammerer should receive treatment as early as possible, before this incorrect speech pattern has become a habit. In cases where the parents are worried because they think their child is developing a stammer, the doctor should refer to the speech therapist immediately, so that she can either reassure and advise the parents or commence treatment of the stammer.

Treatment is very varied, for the speech therapist is not dealing with a series of sounds produced incorrectly but a way of speaking that is incorrect, and each stammerer has his own peculiarities of speech. Although treatment is varied there are certain methods included in every individual treatment:-

- (i) Relaxation is all important and should help to lessen tension.
- (ii) Reading is also useful as the stammerer is no longer using his own words but those of someone else, and he generally becomes less self-conscious and is able to read more fluently.
- (iii) Breathing—often a faulty breathing pattern has been set up because the effort of utterance produces tension inhibiting easy movements of the muscles involved in breathing. This faulty pattern is broken down and by giving breathing exercises an attempt is made to establish a natural co-ordination of the muscles.
- (iv) Negative practice—This is an exercise in which the stammerer goes over any words or sounds that present difficulty and consciously tries to stammer on these words—the idea being that he should realise exactly how he stammers and it is then hoped will be able to help himself when away from the clinic.

Stammering is a wide and controversial subject and much could be written about this speech problem, but the aim of the speech therapist is to reduce the number of young school age and adolescent stammerers who are attending the clinics.

Hearing loss (d.b.) in better ear of children who attended the Units during 1958:-

HANDICAPPED PUPILS—SUMMARY OF POSITION AT 31st DECEMBER, 1958

Type of Handicap	Number on Register 31st December		Receiving Appropriate Education		(a) Number in Residential Schools (b) Number attending Day Schools		Not in receipt of appropriate education, but on waiting list for such		Remarks
	M	F	M	F	M	F	M	F	
(a) Blind	1	1	1	1	(a) 1	1	—	—	
(b) Partially Sighted	3	5	3	5	(a) 3	5	—	—	
(c) Deaf	3	—	3	—	(a) 2	1	—	—	
(d) Partially deaf	105	77	103	77	(a) 1 (b) 8 (c) 94	3 6 68	— 2 —	— — —	(b) in special classes at George Palmer and New Town Schools (c) at ordinary school
(e) Educationally subnormal	97	51	76	46	(a) 1 (b) 75	1 45	(a) 3 (b) 18	— 5	
(f) Epileptic	16	9	16	9	(a) 2	—	(a) 1	—	
(g) Maladjusted	18	11	15	10	(a) 9 (b) 6	4 6	(a) 2 (b) 1	— 1	(b) Child Guidance Hostels
(h) Physically Handicapped	29	18	27	18	(a) 2 (b) 25	2 16	(a) 1 (b) 1	— —	
(i) Delicate Children	20	4	20	4	(a) 1 (b) 19	— 4	— —	— —	
(j) Speech Defects	114	35	114	35	(a) 2 (b) 112	— 35	— —	— —	

The Avenue Special School

Mr. G. Ross, M.A., Headmaster, reports:—

The opening of the new extension to the school in January provided for the handicapped children the accommodation and facilities for which we have waited so long. Surrounded by the old gardens of Whitley Rise, the site will eventually become one of the most pleasant in Reading. In addition to the four classrooms and physiotherapy room there is splendid accommodation for housecraft. The benefit of this was very soon reflected in the pride and interest of all the senior girls, and the boys have incidentally gained a privilege in having most willing hostesses to entertain visiting football teams.

The east wing has been planned to meet the needs of severely handicapped children. Classroom, therapy room, changing room, and toilets are grouped together. This classroom is reserved for the small group of spastic children who formerly received their teaching at home or at Battle Hospital.

The transfer of the physically handicapped and delicate children to the new building permitted a large intake to the E.S.N. department and the first step in the reorganisation of this department was taken by the admission of forty-seven boys and girls. Altogether throughout the year thirty-five boys and twenty-two girls left for employment and they were fitted into appropriate jobs with the help of the Youth Employment officers. All settled into work most satisfactorily. A boy and a girl left us for residential treatment and two boys were transferred to the Occupation Centre. There were seventy-four boys and forty-four girls on the roll at the end of the year.

There was some change and further diminution in the number of delicate children attending the school. Four boys and two girls left for employment and first reports indicate good placement and satisfactory progress. One boy was transferred to residential school and three boys and four girls returned to their former schools. Four boys and two girls were admitted to the department. The opportunity was taken on the opening of the new extension to separate the older, formerly delicate children, who continued to suffer from some measure of debility. They were all boys with varying degrees of educational difficulty and they remained in the old classroom to form a special group small enough to give intensive individual attention preparatory to their returning to normal school or leaving for employment. Excluding this group, there remained fifteen boys and nine girls on the roll of the delicate department.

There was an increase of only one in the roll of the physically handicapped department. Four boys and one girl were admitted but one boy was transferred to secondary school and another boy left for employment. Two boys suffering from cerebral palsy were admitted to the Ministry of Labour Centre at Egham for assessment as to trainability. Both boys were found to be too handicapped unfortunately to train for other than sheltered employment and since establishments providing such employment are very few, they will have a long wait before admission. Meantime occupational therapy and some social activity is provided under the scheme for such handicapped persons. There remained nineteen boys and twelve girls in the department.

The small numbers of delicate and physically handicapped children of secondary school age prompted the combination of the two groups in one classroom in the new extension. This has proven most satisfactory largely because the difference between these children within the school has been one of classification rather than of fact. For the purpose of domestic science, however, the girls here divided into two groups, one very small, consisting of the physically handicapped for whom special care and modified schemes are necessary, the other, still a small one, was of the more physically able girls.



CEREBRAL PALSY UNIT, Avenue Special School

The interest which the boys and girls take in the school garden did not diminish in spite of the indifferent weather for perhaps everything but fruit harvest. However, it was a signal lesson of man's limitations that, in spite of the most gallant concerted efforts, the gladioli and more exotic flowers were not ready for the making of bouquets when His Worship the Mayor and the Mayoress were our guests on Prize Day. That again was a memorable day. So too was the outing to Hayling Island. The sports and swimming gala have now been established as special days on the school calendar. Incidentally, thirty-eight children were awarded the certificates of the Schools Swimming Association for competency at the various grades.

Home Teaching. A genuine appreciation of the work of the home teacher would not be possible without knowledge of the type of cases undertaken and for this reason a brief history of the children receiving home teaching is included.

New Cases in 1958

- (1)— A boy of seven years suffering from dermato-myositis and occasional epileptic attacks. Since this condition first became manifest he has been unable to attend school and has alternated between hospital and home. Teaching in the home has been a great aid to his morale but unfortunately his physical condition has been such as to preclude all but a minimum of academic work.
- (2)— An educationally subnormal girl aged thirteen years who showed signs of an early psychosis. Home teaching seemed to exert a stabilising effect and fortunately her condition improved sufficiently for her to be admitted to the appropriate department at the Avenue School.
- (3)— A girl of fourteen years attending a private school was confined at home for a period of convalescence following a mild and non-infectious attack of pulmonary tuberculosis. A bright and intelligent child, she derived the very maximum benefit from her lessons.
- (4)— A boy aged fourteen years with an extensive fracture of the right femur which has been rather slow in uniting. He wears a plastic spica which makes prolonged sitting very uncomfortable and finds stairs an added hazard. For this reason he has been unable to resume his schooling although home teaching has maintained his educational standards. Curiously enough the individual attention he has received has awakened a latent desire for learning and from being rather indifferent in his attitude to school work, he is now anxious to stay on for an extra year when he returns to school.
- (5)— A boy aged seventeen years attending a secondary school. Post-poliomyelitis paresis necessitated his wearing a spinal brace and leg caliper. The strain of attending school full time, following a severe illness, became too much for him and a period of home teaching was introduced to allow him to recuperate physically. He returned to school at the end of the year and hopes to take his G.C.E. in five subjects.
- (6)— A boy, twelve years old, who started grammar school only last September and so burned his legs on Guy Fawkes night that skin grafting was necessary to heal his injuries. He will soon be back to his studies at school and he has worked hard with his teacher in hospital to maintain his standards.
- (7)— A girl of six years who, although on the blind register, was awaiting re-classification as a partially-sighted pupil. During the interregnum she was given home lessons.

Cases continued from previous year:-

- (1)— A boy of eight years with a left-sided hemiparesis due to an unspecified encephalopathy. His physical condition has remained stationary and educationally he has made a little progress. Home teaching in the morning and attendance at the Avenue School in the afternoon has done much to improve his morale.
- (2)— A girl of thirteen years of an extreme obesity, weighing between 17 and 18 stones. She is quite normal mentally and maintains satisfactory educational progress but unfortunately her physical condition has not improved.
- (3)— A fourteen-year-old girl suffering from a juvenile psychosis mainly evinced in a refusal to attend school or even to meet individual strangers. Her condition deteriorated to such an extent that in the end she would not have anything to do with her home teacher who was obliged to suspend lessons. During the year she reached school-leaving age and this would have seemed worked a notable cure as the last information we had of her was that she was successfully earning her living as a shop assistant.
- (4)— A girl of fourteen years with fragilitas osseum who had been confined to a frame in a hospital ward for some years. We provided a spinal carriage for her in 1956 and this enabled her to have frequent outings from hospital and on many occasions to share home teaching with other children at the home teacher's private residence. Although her physical condition made little progress, her greater confidence and educational attainments made it possible for her admission to a residential school during the year.
- (5)— An epileptic, educationally subnormal boy aged nine years, who was admitted during the year to the appropriate department of the Avenue School. The severity of his epileptic attacks has occasioned further brain damage and his intellectual ability has further deteriorated during the year.

Those who are familiar with the work of the home teachers will appreciate the pleasure and encouragement which their services bring to the child isolated in the home by disease or injury. It is quite remarkable how these children anticipate and enjoy their lessons, although where the physical condition is gross, these can only be regarded as a form of occupational therapy. Those able to derive the full benefit often make more progress in purely academic subjects, and individual tuition would certainly appear to give them zest for knowledge that might astonish their more fortunate comrades of the school world.

SCHOOL DENTAL SERVICE

Mr. J. Campbell, L.D.S., R.C.S., reports as follows:-

The year 1958 has been a difficult one as far as the Dental Service is concerned. At its commencement there was only one full-time Dental Officer, namely myself, and this condition of affairs continued for the major proportion of the year, as a part-time Officer who commenced duty in May only worked three sessions per week. While all assistance is valuable, three sessions per week are, in my opinion, not sufficient and I would recommend that any part-time Officer should work six or more sessions, in order that the service may benefit.

We were fortunate, however, in securing the services of a Dental Officer on a ten-session weekly basis, and he commenced duty on the 1st October. This was a definite improvement but at present we require at least two more full-time Dental Officers in order to cover the area in a reasonable manner. A great number of children have attended General Dental Practitioners and that has been extremely fortunate as working alone, I could only touch a fringe of the work required.

Twenty-five schools have been inspected and this has increased the total number of routine inspections by 2,393 over the previous year. The number of casualties has shown a decrease of 232. The number of entrant infants examined amounted to 741 of whom slightly less than half required treatment. The approximate percentage of acceptance of treatment at the School Clinic was 57% of the number found to require treatment.

Comparing with the previous year, fillings have dropped slightly but the number of teeth conserved has increased and the number of extractions has dropped appreciably.

Oral Hygiene. There has been an increase of 486 patients in this department. Two thousand and fifty-three children made a total of 2,092 attendances. The first figure is composed of 1,402 children who required other dental treatment and 651 who were found at inspection to require cleaning and polishing only.

Instruction in oral hygiene was given in a number of schools during the year. Eight attendances were made by patients from the Occupation Centre, two from St. Joseph's Convent, and one from the Bluecoat School.

Dentures. The number of dentures supplied to children numbered 30 and repairs to existing dentures 6. As I have stated previously, too many dentures were necessary owing to neglect and delay in applying for treatment until the teeth were beyond any hope of conservation. This is regrettable but unfortunately unavoidable under the present under-staffed conditions of the Service.

Orthodontics. There were fewer cases undertaken than in 1957, but the number carried forward was the same. Repairs and additions to appliances numbered 15. A great number of requests are made for this treatment but in a large number of cases the irregularity is very slight and merely a case of appearance. These requests must be refused and the work confined to cases where there is a marked irregularity with a functional handicap. The number of cases discharged with satisfactory results was 34, being an increase of 15 over the 1957 figure. I am pleased to say that the cases abandoned, owing to non-co-operation of the patients, were fortunately less than the previous year. I would like to add that parents are very appreciative of this treatment and this is extremely gratifying to the Dental Officers performing the work.

The following tables give details of the work performed during the year:-

Dental Inspection and Treatment Carried Out by the Authority

(1) Number of pupils inspected by the Authority's Dental Officers:-

(a) At Periodic Inspections	...	...	...	...	7643	
(b) As Specials	...	...	...	...	1103	
					Total (1)	8746
(2) Number found to require treatment	...	...	...			4539
(3) Number offered treatment	...	...	...	...		4382
(4) Number actually treated	...	...	...	...		2630
(5) Number of attendances for treatment	...	...	...			5938
(6) Half-days devoted to: Periodic Inspection	...	...	...		45	
Treatment	...	...	...		621	
					Total (6)	666

(7)	Fillings: Permanent Teeth ...	...	...	...	...	3134	
	Temporary Teeth ...	...	...	...	...	499	
					Total (7)		3633
(8)	Number of teeth filled: Permanent Teeth	...	...	...	...	2764	
	Temporary Teeth	...	...	...	...	473	
					Total (8)		3237
(9)	Extractions: Permanent Teeth	...	...	...	...	657	
	Temporary Teeth	...	...	...	...	1458	
					Total (9)		2115
(10)	Administration of General Anaesthetics	...	...	...	...		681
(11)	Orthodontics: (a) Cases commenced during year	...	...	...	...		21
	(b) Cases carried forward from previous year	...	...	...	...		51
	(c) Cases completed during year	...	...	...	...		34
	(d) Cases discontinued during year	...	...	...	...		8
	(e) Pupils treated with appliances	...	...	...	...		21
	(f) Removable appliances	...	...	...	...		16
	(g) Fixed appliances	...	...	...	...		6
	(h) Total attendances	...	...	...	...		416
(12)	Number of pupils supplied with dentures	...	...	...	...		30
(13)	Other operations: Permanent Teeth	...	...	...	...	727	
	Temporary Teeth	...	...	...	...	793	
					Total (13)		1520

The following table gives the items of treatment of scholarship children who attend non-council schools and also includes patients from the Occupational Centre:-

	No. Treated	No. Attendances	No. Extractions	No. Fillings	No. Anaesthetics	No. Discharged
Blue Coat School	1	1	—	—	—	1
Christ's Hospital	3	11	3	7	—	2
St. Joseph's ...	1	2	1	—	1	1
Occupation Centre	16	52	17	8	8	14

PREVENTION AND TREATMENT

1. **B.C.G. Vaccination.** The vaccination of children born in 1944 was completed during the year and the final results are shown below. The figures in parenthesis are those actually vaccinated in 1958.

No. Selected	Accept- ances	%	Absent	Skin Tested	Pos.	Neg.	Abs.	Pos. %	Received B.C.G.
1583 (827)	1062 (600)	67	57	1005 (448)	102 (38)	861 (391)	42	10.2	847 (380)

B.C.G. Control Centre—A control centre under the direction of Dr. K. Neville Irvine was formed by the Principal School Medical Officers of local authorities in the Oxford Region with the object of making clinical observations on a sample of each batch of Glaxo dried B.C.G. vaccine issued for use in Britain, and of reporting the result as soon as possible to the Ministry of Health and Glaxo laboratories. It was agreed that this investigation would apply only to school children in the thirteen-year-old group which, for the purpose of this report, means those born in 1945, and that its probable duration would be at least two years. From our viewpoint the only changes in procedure, apart from certain alterations in the recording of information and results, was that the Heaf method of tuberculin testing has been adopted in place of the Mantoux. Up to the present, school medical officers carrying out B.C.G. vaccination in Reading have always preferred the Mantoux technique as being more accurate and speedy of application, but as the Heaf test was the method of choice of the majority of the Control Committee, we have conformed with this decision. The Control Centre was introduced in September, 1958 and we were able to vaccinate one batch of the 1945 group before the end of the year.

No. Selected	Accept- ances	%	Absent	Skin Tested	Pos.	Neg.	Abs.	%	Received B.C.G.
160	136	85	19	117	97	7	13	6.7	97

2. **Investigation of Tuberculosis contacts.** Altogether twelve children studying at maintained schools were notified as cases of pulmonary tuberculosis in 1958 and of these, eight were primary infections, the remaining four being of the adult type. None of the latter were found to be infectious on investigation and, since the source of the disease in each instance was unequivocally established within the domestic circle, there was no necessity to carry out investigations at the schools attended by these children.

3. **Mantoux testing in individual cases.** The Mantoux test was used quite extensively during the year as a useful adjunct in the examination of individual children whose symptoms of illness or domestic history might indicate a possibility of tuberculosis.

4. **Ultra-Violet Light Therapy.** This was available during the year at the Queen's Road Clinic and Whitley Clinic. Sunlight treatment is always very popular with the children and since it is rarely that good fun and good advice coincide, they derive maximum benefit from these sessions.

32 boys }
44 girls } received an average of 90 minutes each

Children treated were in the 5-11 years age group.

5. **Ringworm Clinic.** During 1958 there was an outbreak of animal ringworm in the area bounded by:—

Basingstoke Road—South
Whitley Wood Road—East
Shinfield Road—North
Christchurch Road—West

Fifteen cases attended Whitley Clinic and were confirmed after examination under Wood's light. Of these, ten were ringworm of the scalp and, in each instance, hairs were sent to the London School of Hygiene and Tropical Medicine and the diagnosis of *microsporon canis* substantiated.

In six of the households involved there was an animal (two dogs, four cats) and, with the exception of one dog, these were examined under Wood's light or by a veterinary surgeon. All results were negative and in no case could ringworm be definitely traced to an individual animal. The children concerned were seen at the Clinic on at least one occasion, although some subsequently attended the skin clinic of the Royal Berkshire Hospital or received treatment from their own doctor.

A further eleven cases of sporadic nature were diagnosed and of these five were referred to the hospital skin clinic and three received X-ray treatment. In all seventy-eight contacts were examined and the average absence from school of infected cases was four to eight weeks.

Ringworm of the Scalp

	Total	School Age	Pre-School Age	Boys	Girls
Number of Cases treated	11	9	2	9	2
Number of Cases referred to Royal Berkshire Hospital	5	4	1	—	—
No. given X-ray Treatment	3	2	1	3	—
Number of Contacts examined	78	—	—	—	—

Average Absence from School:— 4-8 weeks

6. **Remedial Exercises.** One hundred and twenty-nine children were advised to do remedial exercises for skeletal defects during the year. The number in each category is listed below:—

Flat Feet	40
Postural Exercises	69
Breathing Exercises	14
Postural and Breathing Exercises	6

A further 139 children who had poor chest expansion, breathing defects, or asthma, were recommended for breathing exercises. The breathing exercises advised were deliberately chosen for their simplicity, for to younger children they can be presented as an amusement rather than a penance. As a means of re-educating children in the correct usage of respiratory muscles and passages and in the development of the lung potential, these exercises are of the foremost assistance and act as a positive reinforcement of bodily health. Illustrated leaflets demonstrating the exercises appropriate to the defect were given to each child in the above categories.

7. Minor Ailments Clinics. Six hundred and twenty-three children received treatment for minor ailments. The main complaints were skin diseases, suspected fractures, bruises and eye conditions.

8. Medical Examinations. The medical examination of school children, whether at periodic or at special inspections is the major duty undertaken by school doctors. To some observers the examination of ostensibly fit children may seem a monotonous and unrewarding chore but it is surprising how often children, seemingly in the best physical condition are found to have defects or difficulties of which no sustained complaint is made. It is true that most of these are of a relatively insignificant nature—flat feet, bad posture, minor inaccuracies of vision, etc., although even in these instances diagnosis is important to prevent more serious conditions developing. But apart from such minutiae, opportunities are given to parents to discuss problems of educational failure or domestic indiscipline and to bring forward worries concerning their child's health that previously had appeared of little import or had been deliberately or unconsciously suppressed.

The yield from medical inspections is variously described in this report and the bare bones of statistical detail are embodied in the tables of the final section. It might, however, be pertinent to record here a few examples of the number of children detected at medical inspections in the past year to be suffering from defects either preventable or amenable to treatment.

Catarrhal infection of the upper respiratory passages	110
Cervical gland enlargement	122
Enuresis	107
Skin diseases	327
Flat feet	222
Bad posture	144
Knock knees	92
Tonsillar infections	324
Congenital heart defects	12
Rheumatic heart disease	5
Functional heart murmurs	77
Chorea	2
Asthma	92
Diabetes	9

HEALTH EDUCATION

During the year the School Medical Officers gave to parent-teacher and other interested associations a number of talks and lectures on subjects concerning the health of the school child. The school nurses also carried out an extensive programme within the schools themselves.

Miss M. Webber, Superintendent Health Visitor/School Nurse reports:-

Selected school nurses/health visitors have continued the talks on parentcraft to the secondary modern school girls. Each school is taken as individual and although a definite syllabus is laid down in conjunction with that of the Housecraft syllabus of the Education Department, emphasis is made on the necessary requirements of each school and the Health Visitor/School Nurse carrying out the course of talks and demonstrations, discusses with the Housecraft teacher of each school she attends the

programme she will give. Close co-operation has been kept with the Housecraft Organiser for the Education Department and we are very much indebted for all her help and guidance.

93 classes have been given throughout the year.

PHYSICAL EDUCATION

The organisers of Physical Education report:-

The shortage of women specialist teachers, mentioned in our last report, was remedied to some extent by the beginning of the Christmas Term and, in consequence, secondary departments have had the benefit of qualified staff during the year. The enthusiasm of these teachers has had a marked effect on girls' physical education particularly in out-of-school work where determined efforts have been made to widen the choice of activities for the older pupils. Canoeing, camping and walking have been introduced to augment the general games programme.

It would have been pleasing to have anticipated that staffing difficulties had been settled for several years, but by the Summer Term further problems had arisen. At the end of the year there were vacancies for five women specialists and four other posts were filled by part-time teachers. Also, for the first time, similar difficulties were present in the boys' schools where normally there are less frequent changes of staff. Six vacancies arose during the Summer Term and while all but one were filled it was not possible to appoint fully trained specialists for each post as there is an acute shortage of teachers of physical education. Nevertheless, in spite of these difficulties, there has been no lessening of effort or enthusiasm at any school. We have tried to improve facilities where possible by supplying new equipment and plans are in hand to modernise the gymnasium at Caversham Secondary School. In the primary schools, a climbing frame has been erected indoors at Alfred Sutton and similar installations are in mind for Whitley Park and Geoffrey Field Junior Schools.

Playing Fields. The appointment of a Supervisor of School Playing Fields has helped greatly to increase the general efficiency of the maintenance of playing fields. The requirements of schools on these fields, especially for out-of-school games, increases each year with the result that heavier demands are made on staff and machinery to maintain the grounds at a reasonable standard. The playing field at Hugh Faringdon School was taken over from the contractor and on this occasion it is gratifying to report that the general condition of the field at this stage was satisfactory. This field may be ready for use next Spring.

The postponement of the construction of the hard tennis courts at the Grove Playing Field was a disappointment and has meant considerable difficulty in arranging tennis practice for schools in the Caversham area. It was noticeable that only one school from this district entered for the annual schools' Tennis Tournament. We look forward to the time when the courts at the Grove and also at Southlands are completed.

Playgrounds. Much of our work is carried out in school playgrounds and it is important, therefore, that the surface of these areas should be satisfactory—level, free from dust, and well drained. It has been noticed and reported that the materials being used at present for the construction of new playgrounds and for re-surfacing are not meeting these requirements. This might be borne in mind when future contracts are being considered.

Swimming. During the year 43,326 attendances at public baths were recorded and while this figure is 4,000 fewer than the previous year, the total stated does not include the number of children swimming in the learners' pool at the Hill School and Emmer Green School, or those making use of the bath at Queen Anne's School.

The enthusiasm for swimming increases each year as parents become more conscious of its importance for their children. Experience with the learners' pool has shown that the best results are obtained between the ages of 6 and 8 years, but unfortunately it is not possible to include these age groups for tuition at the public baths where there are no facilities for such small children. The learners' pools at schools are the immediate solution to the problem in Reading and several schools are raising funds towards the cost of building. Geoffrey Field Junior School heads the list, having raised over £800.

We are indebted to the Head Mistress of Queen Anne's School for putting the swimming bath at our disposal on two afternoons each week during the Summer Term. These excellent and pleasant facilities were much appreciated by the schools concerned.

Courses. The following courses were arranged for teachers during the year:—

- Hockey—Secondary Schools
- Netball—Secondary Schools
- Association Football—Secondary Schools
- Movement—Primary Schools
- Folk Dancing

In addition, teachers were encouraged to attend holiday courses.

In concluding our report we wish to thank everyone who has helped us in our work during the year.

ROAD ACCIDENTS

We are indebted to Mr. J. Lawrence, the Chief Constable, for the following information:—

In this Borough the year 1958 was marred by the tragic deaths on the road of 3 young schoolchildren, a girl aged 13 years and 2 boys aged 10 and 11 years respectively. The girl was knocked over by a trolley bus when crossing the road; the 10-year-old boy was riding his pedal cycle during a particularly dark wet evening and when endeavouring to turn to his right was run down by an overtaking trolley bus; and the 11-year-old boy ran out into the road into the path of an oncoming motor van. A full Police investigation was made but in no instance was there any evidence of criminal neglect and a verdict of "Accidental Death" was returned in each case.

A table is given below showing the number of children injured and the age groups. 69 were pedal cyclists including 11 (8 boys and 3 girls) who were seriously injured. In the main, the causes amounted to a lack of road sense as instanced by some of the following, where serious injury was sustained: a girl aged 9 years wobbling and losing control when being overtaken by a motor cyclist; a girl aged 12 years colliding with the rear of a trolley bus which pulled up suddenly; a boy aged 14 years turning right without proper caution; a boy aged 12 years not looking where he was going and running into the back of a stationary van. In two other cases, a boy when riding his pedal cycle was carrying his cricket bat across the handlebars of the machine. The bat slipped and, in trying to stop it, it became jammed in the front wheel and the boy was thrown to the ground. In the other case, a girl was thrown from her bicycle when she tried to stop her mudguard from rattling as she was riding along. One boy aged 9 years lost control of his cycle when travelling down a steep hill.

As to the pedestrians who were seriously injured, four were knocked down when running out into the road in front of oncoming traffic and a fifth was knocked down whilst playing in the road.

The above does, of course, show the need for some sort of training not only in the use of the pedal cycle, but also in the matter of road sense. The National Proficiency Scheme for the training and testing of Child Cyclists is to be put into operation this year with the aim of reducing accidents involving child cyclists. I feel that the scheme is only a beginning and that it has tremendous possibilities. Children are by nature often unpredictable and erratic and words of good advice as to proper road behaviour is sometimes forgotten, only momentarily perhaps, but it is then that the accident occurs. If road safety could be instilled into them from the age at which they are able to take notice, then their reaction to traffic dangers will become instinctive and should remain with them for the rest of their lives. Then, by this means, not only will accidents to children be reduced, but in years to come so will accidents to the adult population, in the same proportion, lessen.

	Fatal	Seriously injured	Slightly injured	Male	Female	AGE											
						5	6	7	8	9	10	11	12	13	14	15	16
January		1	2	3			1			1			1				
February			6	4	2						1		3			1	1
March	2		6	7	1		1			1		1	1	1	1	2	
April			4	3	1						1			1	1		1
May		3	15	14	4	1		1	2	2	2		6	1	1	2	
June		2	11	7	6			2		1	3		1	1	2	2	1
July		3	11	7	7		1				1	3	3	3	1	2	
August		1	7	4	4			1	1	2	2			2			
September		2	11	8	5	1	4			1		4			2	1	
October	1	3	11	11	4			1	1	1	2	4	1	2	2	1	
November		1	2	2	1					1	1					1	
December		3	9	5	7		1			1		4	2		2	2	
Totals	3	19	95	75	42	2	8	5	4	11	13	16	18	11	12	14	3

SPECIAL INVESTIGATIONS

Colour Vision in School Children. Dr. Brian Smith reports:—

As was stated in the 1957 report, it has been felt that an assessment of colour vision at the age of 14 years is too late for practical advice about future employment to be given. For this reason an investigation of colour vision was carried out to determine: (a) How accurate is the information given by the Ishihara test; and (b) At what age an accurate result is obtainable.

After a large number of children had been tested it was found convenient to restrict the survey to the boys in Ashmead and Stoneham Schools when routine medical examinations were carried out. The boys were tested in a room well illuminated by daylight and the Ishihara test plates were held at a distance of 18-in. to 2-ft. from the eyes. Both eyes were tested together and for convenience the odd

numbered plates only were used. These form a series complete in themselves. It was immediately found that over 90% of children tested in the 14-year-old group made at least one mistake on the plates and 45% made two or more mistakes. At this stage it was decided to subject all these who made more than two mistakes on the plates (i.e. 13.9% of those tested) to the Giles Archer lantern test.

It was found on lantern testing that many boys who made a number of mistakes on the Ishihara test made only minor errors on the lantern test which indicated that their defect of colour vision was not as severe as appeared at first, and that the number of errors on the Ishihara plates was not closely related to the severity of defect of colour vision.

The conclusions reached after a study of 367 children are:—

1. The Ishihara test shows the type of colour defect but not its severity.
2. The lantern test confirms the type of defect and indicates the severity of defect.
3. The mistakes on the Ishihara test must be accepted as normal, as all making two or less mistakes pass the lantern test.
4. The Ishihara test is a sensitive test and it would not be fair to suggest that those who make more than two mistakes have significant colour defects until lantern testing is carried out.

In addition to the survey on 14-year-old boys, a number of children were tested at the intermediate examination at about 11 years of age. It was found that the results gained at this age gave approximately the same percentage of failures as those tested at the age of 14. This indicates that at 11 years of age the Ishihara test is reliable and could be used at the intermediate examination. There is no doubt that at this age any information concerning defects of colour vision would be more useful than at 14 years as it would then be known early enough to be taken into account when the question of future careers arose. There still remains the difficulty of giving definite advice on employment as for only a few careers in industry, transport undertakings and the Services, is a definite standard of colour vision specified. The answer is clearly that we should consider each case on its merits and should avoid what has often been done in the past, that is, telling a child who fails a few plates on the Ishihara test that he is "colour blind." He may have a defect of colour vision, but its severity can only be assessed by lantern testing.

RESULTS OF ISHIHARA TESTING

					%	
No. tested (14 years old)	367			} All passed Lantern test.
No. with no mistakes	...	...	33	9	
No. with 1 mistake	...	...	171	46.6	
No. with 2 mistakes	...	...	112	30.5	
No. with 3 mistakes	10	2.7		} Some passed Lantern test. Others showed defects of varying severity.
No. with more than 3 mistakes	...	...	41	11.2	

STATISTICAL DATA

PART I

Medical Inspection of pupils attending maintained and assisted Primary and Secondary Schools (including Nursery and Special Schools).

(A) Periodic Medical Inspections

Age Groups Inspected (By year of birth)	No. of Pupils Inspected	Physical Condition of Pupils Inspected			
		SATISFACTORY		UNSATISFACTORY	
		No.	% of Col. 2	No.	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)
1954 and later	261	261	100%	—	—
1953	775	770	99.3%	5	.6%
1952	739	732	99.05%	7	.9%
1951	62	62	100%	—	—
1950	520	518	99.7%	2	.3%
1949	70	70	100%	—	—
1948	63	63	100%	—	—
1947	49	49	100%	—	—
1946	414	410	99.03%	4	.9%
1945	174	173	99.4%	1	.5%
1944	570	568	99.6%	2	.3%
1943 and earlier	958	952	99.4%	6	.6%
Total	4,655	4,628	99.4%	27	.6%

(B) Pupils found to require treatment at Periodic Medical Inspections

Age Groups Inspected (By year of birth)	For defective vision (excluding squint)	For any of the other conditions recorded in Part II	Total individual pupils
1954 and later	—	31	29
1953	25	93	110
1952	26	101	111
1951	3	5	7
1950	20	55	66
1949	2	6	7
1948	3	14	15
1947	2	4	6
1946	46	28	73
1945	26	25	45
1944	47	36	77
1943 and earlier	117	91	187
Total	317	489	733

(C) Other Inspections

Number of Special Inspections	...	...	...	964
Number of Re-inspections	...	...	...	1,174
Total				2,138

(D) Infestation with Vermin

(a)	Total number of individual examinations of pupils in schools by school nurses or other authorised persons	...	...	...	36,572
(b)	Total number of individual pupils found to be infested	...	...	...	550
(c)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2) Education Act, 1944)	...	...	...	3
(d)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3) Education Act, 1944)	...	...	...	—

PART II

Defects found by Medical Inspection during the year.

(A) Periodic Inspections

Defect or Disease	PERIODIC INSPECTIONS							
	Entrants		Leavers		Others		Total	
	(T)	(O)	(T)	(O)	(T)	(O)	(T)	(O)
Skin	8	13	15	15	24	25	47	53
Eyes— <i>a.</i> Vision	51	66	141	86	125	48	317	200
<i>b.</i> Squint	22	10	6	8	21	11	49	29
<i>c.</i> Other	4	5	4	17	4	6	12	28
Ears— <i>a.</i> Hearing	16	35	4	13	5	14	25	62
<i>b.</i> Otitis Media	7	15	5	7	2	8	14	30
<i>c.</i> Other	5	4	2	8	4	5	11	17
Nose and Throat	44	84	5	9	35	54	84	147
Speech... ..	14	14	2	3	8	12	24	29
Lymphatic Glands	2	31	—	9	1	27	3	67
Heart	3	13	1	9	2	18	6	40
Lungs	6	32	1	9	12	29	19	70
Developmental— <i>a.</i> Hernia... ..	5	2	1	—	1	3	7	5
<i>b.</i> Other	4	18	5	19	16	25	25	62
Orthopaedic— <i>a.</i> Posture	6	3	18	11	11	10	35	24
<i>b.</i> Feet	30	18	9	8	20	26	59	52
<i>c.</i> Other	13	21	27	26	25	41	65	88
Nervous System— <i>a.</i> Epilepsy	1	4	3	1	—	2	4	7
<i>b.</i> Other... ..	1	24	2	2	3	20	6	46
Psychological— <i>a.</i> Development	3	6	—	6	3	7	6	19
<i>b.</i> Stability	—	10	2	7	7	11	9	28
Abdomen	1	2	—	—	—	—	1	2
Other	3	2	1	1	—	1	5	3

(T)=Treatment

(O)=Observation

(B) Special Inspections

Defect or Disease	SPECIAL INSPECTIONS	
	Pupils requiring Treatment	Pupils requiring Observation
Skin	280	—
Eyes— <i>a.</i> Vision	33	5
<i>b.</i> Squint	2	3
<i>c.</i> Other	56	5
Ears— <i>a.</i> Hearing	10	9
<i>b.</i> Otitis Media	2	3
<i>c.</i> Other	49	1
Nose and Throat	41	10
Speech	12	6
Lymphatic Glands	2	2
Heart	1	2
Lungs	13	4
Developmental— <i>a.</i> Hernia... ..	—	1
<i>b.</i> Other	4	8
Orthopaedic— <i>a.</i> Posture	2	—
<i>b.</i> Feet	13	2
<i>c.</i> Other	22	7
Nervous System— <i>a.</i> Epilepsy	4	3
<i>b.</i> Other	4	11
Psychological— <i>a.</i> Development	57	39
<i>b.</i> Stability	7	12
Abdomen	19	1
Other	721	4

PART III

Treatment of pupils attending maintained and assisted Primary and Secondary Schools (including Nursery and Special Schools)

(A) Eye Diseases, Defective Vision and Squint

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	68
Errors of refraction (including squint)	401
Total	469
Number of pupils for whom spectacles were prescribed ...	373

(B) Diseases and Defects of Ear, Nose and Throat

	Number of cases known to have been dealt with
Received operative treatment:—	
(a) for diseases of the ear	16
(b) for adenoids and chronic tonsillitis	282
(c) for other nose and throat conditions	16
Received other forms of treatment	72
Total	386
Total number of pupils in schools who are known to have been provided with hearing aids:—	
(a) In 1958	3
(b) In previous years	36

(C) Orthopaedic and Postural Defects

	Number of cases known to have been treated
(a) Pupils treated at clinics or out-patients departments ...	20
(b) Pupils treated at school for postural defects	40
Total	60

(D) Diseases of the Skin

	Number of cases known to have been treated
Ringworm—(a) Scalp	11
(b) Body	8
Scabies	4
Impetigo	26
Other skin diseases	195
Total	244

(E) Child Guidance Treatment

	Number of cases known to have been treated
Pupils treated at Child Guidance Clinics	62

(F) Speech Therapy

	Number of cases known to have been treated
Pupils treated by speech therapists	251

(G) Other Treatment Given

	Number of cases known to have been treated
(a) Pupils with minor ailments	623
(b) Pupils who received convalescent treatment under School Health Service arrangements	5
(c) Pupils who received B.C.G. vaccination	477
(d) Pupils who received U.V.L. therapy	76
Total	1,181

Cases of Infectious Disease in School and Pre-School Children for the year 1958

	At All Ages	Under 1 year	1 and under 3 years	3 and under 5 years	5 and under 10 years	10 and under 15 years
Scarlet Fever... ..	263	1	22	68	154	18
Whooping Cough	76	7	16	20	33	—
Measles	105	5	32	23	44	1
Acute Pneumonia (Primary or Influenzal) ...	13	4	5	3	1	—
Cerebro Spinal Fever	—	—	—	—	—	—
Acute Poliomyelitis (Paralytic)	1	—	—	—	1	—
Acute Poliomyelitis (Non-Paralytic)	1	—	—	—	—	1
Diphtheria	—	—	—	—	—	—
Enteric or Typhoid Fever (excluding Paratyphoid) ...	—	—	—	—	—	—
Food Poisoning	—	—	—	—	—	—
Erysipelas	2	—	1	—	—	1
Dysentery	3	1	—	2	—	—
Meningococcal Infection	1	1	—	—	—	—
Acute Encephelitis (Infective)	—	—	—	—	—	—
	465	19	76	116	233	21

